

FLORIDA TITLE XIX LONG-TERM CARE REIMBURSEMENT PLAN

VERSION ~~XVIII~~^{XVII} EFFECTIVE DATE: _____

I. Cost Finding and Cost Reporting

- A. Each provider participating in the Florida Medicaid nursing home program shall submit a uniform cost report and related documents required by this plan using Agency for Health Care Administration (AHCA) form AHCA 5100-000, Rev. 7-1-90, as revised and prepared in accordance with the related instructions, postmarked or accepted by a common carrier no later than 3 calendar months after the close of its cost reporting year. Upon written request, AHCA shall grant an extension of time for filing cost reports. ~~Three~~^{Four} complete, legible copies of the cost report shall be submitted to AHCA.
- B. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. For a new provider with no cost history in a newly constructed or existing facility entering the program or an existing provider in a newly constructed replacement facility, the interim operating and patient care cost per diems shall be the lesser of: the class reimbursement ceiling based on Section V of this Plan, the budgeted operating and patient care cost per diems approved by AHCA based on Section III of this plan, or the average operating and patient care per diems (excluding incentives) in the district in which the facility is located plus 50% of the difference between the average district per diem (excluding incentives) and the facility class ceiling. Existing providers in a newly constructed replacement facility shall receive the greater of the above operating and patient care cost per diems or their current operating and patient care per diems that are in effect prior to the operation of their replacement facility, not to exceed the facility class ceilings. The average district per diem is calculated by taking the sum of all operating and patient care per diems divided by the number

of facilities. For a new provider with no cost history resulting from a change of ownership or operator, where the previous provider participated in the Medicaid program, the interim operating and patient care per diems shall be the lesser of: the class reimbursement ceiling based on Section V of this Plan, the budgeted per diems approved by AHCA based on Section III of this Plan, or the previous providers' operating and patient care cost per diem (excluding incentives), plus 50% of the difference between the previous providers' per diem (excluding incentives) and the class ceiling. The above new provider ceilings, based on the district average per diem or the previous providers' per diem, shall apply to all new providers with a Medicaid certification effective on or after July 1, 1991. The new provider reimbursement limitation above, based on the district average per diem or the previous providers' per diem, which affects providers already in the Medicaid program, shall not apply to these same providers beginning with the rate semester in which the target reimbursement provision in Section V.B.16. of this plan does not apply. This new provider reimbursement limitation shall apply to new providers entering the Medicaid program, even if the new provider enters the program during a rate semester in which Section V.B.16. of this plan does not apply. New provider ceilings applicable to the first rate semester a new provider enters the program shall be the basis for calculating subsequent rate semester new provider target ceilings for that same provider through the following calculation: Effective July 1, 1996, except for only the January 1, 2000 rate semester for the patient care component, establish the target reimbursement for operating and patient care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and patient care cost in Step V.B.16. from the previous rate semester, excluding incentives and the Medicaid Adjustment Rate (MAR) with the quantity:

$$1 + 1.4 \times \frac{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the prospective rate period} - 1}{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the current rate period}}$$

In the above calculation, the 1.4 shall be referred to as the inflation multiplier.

New providers limited by this section for the patient care component for the January 1, 2000 rate semester only shall be entitled to a similar adjustment in the inflation multiplier as described in Section V. B.16.

For new providers who enter the program operating a facility that had been previously operated by a Medicaid provider, the property reimbursement rate shall be established per Section V.E.4. of this plan. The property cost per diem for newly constructed facilities or replacement facilities shall be the lesser of: the budgeted fair rental value rate approved by AHCA based on Section V.E. of this plan; or the applicable fair rental value based upon the cost per bed standard that was in effect 6 months prior to the date the facility was first put in service as a nursing home. Return on equity or use allowance per diems shall be the budgeted rate approved by AHCA per Section III of this plan. Prospective reimbursement rates shall only be set on cost reports for periods of 6 months or more but less than 18 months. Cost reporting periods ending on or after July 1, 1991, shall be for periods 6 months or more but less than 18 months. Interim rates shall be cost settled for the interim rate period, and the cost settlement is subject to the above new provider reimbursement limitations.

- C. The cost report shall be prepared by a Certified Public Accountant in accordance with Chapter 409.908, Florida Statutes, on the form prescribed in Section I.A., and on the accrual basis of accounting in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) as incorporated by reference in Rule 61H1-20.007, F.A.C.,

the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual (HCFA-PUB.15-1) (1993) incorporated herein by reference except as modified by the Florida Title XIX Long Term Care Reimbursement Plan and State of Florida Administrative Rules. For governmental facilities operating on a cash method of accounting, data based on such a method of accounting shall be acceptable. The CPA preparing the cost report shall sign the cost report as the preparer, or, in a separate letter, state the scope of his work and opinion in conformity with generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, F.A.C., and AICPA statements on auditing standards. Cost reports, which are not signed by a Certified Public Accountant, or are not accompanied by a separate letter signed by a CPA, shall not be accepted.

- D. All prior year cost reports must be submitted to and accepted by the Agency, before the current year cost report may be accepted for rate setting. ~~A provider which does not file a cost report within 6 calendar months after the close of its reporting period shall have its provider agreement canceled.~~ If a provider submits a cost report late, after 3 calendar months, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 3 calendar months, then the providers' rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively. The lower rate shall not be paid retroactively if the provider adequately demonstrates, through documentation, that emergency circumstances prevented the provider from submitting the cost report within the prescribed deadline. Similarly, if a provider submits a cost report late because of emergency circumstances, and the use of that cost report would have resulted in higher reimbursement for a rate semester had it been submitted within 3 calendar months, then the provider's rate for that rate semester shall be

retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Emergency circumstances are limited to loss of records from fire, flood, theft or wind.

- E. A provider which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, HCFA-PUB.15-1 (1993) when that provider has been receiving an interim reimbursement rate.
- F. All providers are required to maintain financial and statistical records in accordance with 42 CFR 413.24 (1998~~7~~), sections (a),(b),(c), and (e). The cost report is to be based on financial and statistical records maintained by the facility. Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of cost and other records in accordance with HCFA PUB.15-1 (1993) which pertain to the determination of reasonable costs, and shall be capable of and available for auditing by State and Federal authorities. All accounting and other records shall be brought up to date at the end of each fiscal quarter. These records shall be retained by the provider for a minimum of 5 years following the date of submission of the cost report form to AHCA.

~~G. Chart of Accounts~~

- ~~1. Mandatory use by all facilities. When a chart of accounts is developed by AHCA, it shall be incorporated in this reimbursement plan by a rule amendment and shall be used by all long-term care facilities participating in the Title XIX program in the State of Florida. The chart shall provide for the basic classification of all assets, liabilities, equity, income, and expenses necessary for the preparation of the cost report. The classifications within the chart shall be the minimum requirements, and the~~

~~provider may find it necessary to expand the chart for the management information it considers necessary.~~

~~2. Activities not related to patient care. If the provider conducts activities not related to patient care, additional accounts shall be added to accommodate those activities.~~

GH. Records of related organizations as identified by 42 CFR 413.17 (1998~~7~~) shall be available upon demand to representatives, employees, or contractors of AHCA, the Auditor General, General Accounting Office (GAO), or Department of Health and Human Services (HHS).

HI. AHCA shall retain all uniform cost reports submitted for a period of at least 3 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17 (1998~~7~~). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

II. Audits and Desk Reviews

Cost reports submitted by providers of nursing home care in accordance with this Plan are subject to an audit or desk review on a random basis and at any time the agency has been informed or has reason to believe that a provider has claimed or is claiming reimbursement for unallowable costs. The performance of a desk review does not preclude the performance of an audit at a later date.

A. Description of AHCA's Procedures for Audits-General

1. Primary responsibility for the audit of providers shall be borne by AHCA. The efforts of AHCA audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 (1998~~7~~) will be met.
2. All audits shall be based on generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, F.A.C., of the AICPA.

3. Upon completion of each audit, the auditors shall issue a report which meets the requirements of 42 CFR 447.202 (1998~~7~~) and generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, F.A.C. The Auditor shall declare an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all Federal and State regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for 3 years.
4. The provider's copy of the audit report shall include all audit adjustments and changes and the authority for each, and all audit findings and shall be accompanied by such other documentation as is necessary to clarify such adjustments or findings.

B. Field Audit and Desk Review Procedures

1. Upon receipt of a cost report from the provider prepared in accordance with instructions furnished by the agency, the agency will determine whether an audit or desk review is to be performed. Providers selected for audit or desk review will be notified in writing of the AHCA Audit Office or CPA firm assigned to perform the audit or desk review.
2. Upon completion of an audit or desk review and before publication of the audit or desk review report, the provider shall be given an exit conference at which all findings will be discussed and explained. A copy of the proposed audit or desk review adjustments will be given to the provider at least ten (10) days before the exit conference. If the provider fails to schedule an exit conference within twenty calendar days of receipt of the adjustments, the audit or desk review report will be issued without an exit conference. Desk review exit conferences will be conducted through the mail or in the agency's office in Tallahassee.

3. Following the exit conference, the provider has sixty (60) calendar days to submit documentation or other evidence to contest any disallowed expenditures or other adjustments. For adjustments made due to lack of adequate documentation or lack of support, any documentation received after the sixty day period shall not be considered when revising adjustments made due to lack of adequate documentation or lack of support. However, the sixty-day limitation shall not apply if the provider can adequately demonstrate, through documentation, that emergency circumstances prevented the provider from submitting additional documentation within the prescribed deadline. Emergency circumstances are limited to loss of records from fire, wind, flood or theft.
4. All audit or desk review reports shall be issued by certified mail, return receipt requested and shall be mailed to the address of the nursing home to the attention of the administrator. The provider shall have twenty-one (21) calendar days from the date of receipt of the audit report to challenge any audit or desk review adjustment or audit or desk review finding contained in the report by requesting an administrative hearing in accordance with Section 120.57, Florida Statutes and Chapter 28.10628-5, Florida Administrative Code. The audit or desk review report shall constitute prima facie evidence of the propriety of the adjustments contained therein. The burden of proof is upon the provider to affirmatively demonstrate the entitlement to the Medicaid reimbursement. Except as otherwise provided in this Plan, Chapter 28-10628-5, Florida Administrative Code shall be applicable to any administrative proceeding under this Plan.
5. Collection of overpayments or refunds of amounts collected in error will be in accordance with Section 409.335, Florida Statutes and Rule 59G-9.010.

III. Allowable Costs

- A. All items of expense shall be included on the cost report which providers must incur in meeting:

1. The definition of nursing facilities contained in Sections 1919(a),(b),(c), and (d) of the Social Security Act.
 2. The standards prescribed by the Secretary of HHS for nursing facilities in regulations under the Social Security Act in 42 CFR 483 (19987), Subpart B.
 3. The requirements established by AHCA which is responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610 (19987); and
- B. All therapy required by 42 CFR 409.33 (19997) and Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapies include physical therapy, audiology, speech pathology and occupational therapy.
- C. Implicit in any definition of allowable costs is that those costs shall not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, HCFA-PUB.15-1 (1993) and this plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.
- D. All items of expense which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities, are allowable. The following are examples of expenses that allowable costs for routine services shall include:
- (1) All general nursing services, for example: oxygen and related medications, hand feeding, incontinency care, tray service, and enemas;
 - (2) Items furnished routinely and relatively uniformly to all patients, such as patient gowns, water pitchers, basins, and bedpans;

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- (3) Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, adhesive bandages, antacids, aspirin and other non-legend drugs ordinarily kept on hand, suppositories, and tongue depressors;
 - (4) Items used by individual patients but which are reusable and expected to be available, such as ice bags, bedrails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment;
 - (5) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician because these supplements have been classified by the Food and Drug Administration as a food rather than a drug; and
 - (6) Laundry services other than for personal clothing, prior to October 1, 1993.
 - (7) Effective October 1, 1993, laundry services, including basic personal laundry services , but excluding dry cleaning, mending, handwashing or other specialty services, shall be an allowable cost.
- E. Bad debts other than Title XIX, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX shall be limited to Title XIX uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients' responsibilities. Example: Daily rate is \$34.00; State pays \$26.00 and patient is to pay \$8.00. If Medicaid patient pays only \$6.00, then \$2.00 would be an allowable bad debt. All Medicaid Title XIX bad debts shown on a cost report shall be supported by proof of collection efforts, such as copies of two collection letters, etc.
- F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider by common ownership or control shall be